Personal Health Information Release Form

(HIPAA Release Form)

Name: _____ Date of Birth:____/____/____

Release of Information

[ ] I authorize the release of any and all information including the diagnosis, financial and dental records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse_____

[ ] Parent_____

[ ] Children_____

[ ] Other _____

[ ] Information is NOT to be released to anyone.

This **Release of Information** will remain in effect until terminated by me in writing.

Messages

Please call **[ ]** My home **[ ]** My work **[ ]** My cell Number:_____
If unable to reach me:
[ ] Please leave a detailed message
[ ] Please leave a message asking me to return your call
[ ] Other:_____

The best time to reach me is (Day)_____Between(Time)_____

I understand that this office will try to accommodate my wishes about my contact information, but may have to contact me at other numbers if unable to contact me at my requested number/location.

Signed:_____**Date:**____/_____/_____